Whitley Family Dental

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Patient Name: _____ _____ ____ _____

Last First MI Preferred Name

Medical History

Indicate which of the following you have had or have at present. By checking the box it will indicate a "Yes" response, leaving blank will indicate a "No" response.

- ☐ ADD/ADHD
- ☐ AIDS/HIV
- ☐ Alcohol Addiction
- ☐ Allergy - Acrylic
- ☐ Allergy - Anesthetic
- ☐ Allergy - Aspirin
- ☐ Allergy - Cephalexin
- ☐ Allergy - Clindamycin
- ☐ Allergy - Epinephrin
- ☐ Allergy - Metal
- ☐ Allergy - Other
- ☐ Allergy - Penicillin
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety
- ☐ Arthritis/Gout
- ☐ Artific. Heart Valve
- ☐ Artificial Joint
- ☐ Aspergers
- ☐ Asthma
- ☐ Birth Control IUD
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problems
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Circulatory Problems
- ☐ Cold Sores/Fever Bl.
- ☐ Congential Heart Dis
- ☐ Convulsions
- ☐ Depression
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Easily Winded
- ☐ Emphysema
- ☐ Epilepsy/Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting/Dizziness
- ☐ Fibromyalgia
- ☐ Frequent Cough
- ☐ Frequent Diarrhea
- ☐ Frequent Headaches
- ☐ GERDS
- ☐ Genital Herpes
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack/Failure
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart Trouble/Dis
- ☐ Hemochromotosis
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatits B or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hives or Rash
- ☐ Hypoglycemia
- ☐ Infect. Endocarditis
- ☐ Irregular Heartbeat
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Lupus
- ☐ Medications
- ☐ Mitral Valve Prolaps
- ☐ Multiple Sclerosis
- ☐ Oral Contraceptives
- ☐ Osteoporosis
- ☐ Pain in Jaw (TMD)
- ☐ Parkinsons
- ☐ Persistent Fever
- ☐ Pre-medication
- ☐ Pregnant/Nursing
- ☐ Psychiatric Care
- ☐ Pulmonary Embolism
- ☐ Pulmonary Stenosis
- ☐ Radiation Treatments
- ☐ Recent Weight Loss
- ☐ Renal Dialysis
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Rheumatoid Arthritis
- ☐ Scarlet Fever
- ☐ Seasonal Allergies
- ☐ Sepsis
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Sjogren's Syndrome
- ☐ Sleep Apnea
- ☐ Spina Bifida
- ☐ Steroid Injections
- ☐ Stomach/Intestinal
- ☐ Stroke
- ☐ Surgery
- ☐ Swelling of Limbs
- ☐ Thyroid Disease
- ☐ Tobacco Use
- ☐ Tonsilitis
- ☐ Tuberculosis
- ☐ Tubes in Ears
- ☐ Tumors or Growths
- ☐ Ulcers
- ☐ Vertigo
- ☐ Yellow Jaundice

☐ Recent Hospitalization ☐ Presently being treated for any other illness

If any conditions or alerts selected above needs further clarification, please describe below

_____

_____

_____

Do you take antibiotic PREMEDICATION for your dental visits? If yes, please explain.

Name of physician and date of last physical exam

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

List all MEDICATIONS (prescription and non-prescription), including regular dosages of aspirin. *

Please list any allergies including known drug allergies.

☐ * **By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature.**

HIPAA Acknowledgment

I understand I can review and download/receive a copy of the Whitley Family Dental Notice of Privacy Practices found at www.billwhitleydds.com. I understand that I may inspect or copy any protected health information from my patient file. I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my healthcare and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

Please list the first and last names of any person(s) we may discuss your appointment, treatment, and or financial obligations with:

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.**

Relationship to Patient (Patient, Parent, Guardian, Other) _____

Signature _____ **Date** _____

Response Date: _____